such agencies as leukocytic extract, I feel very definitely that they raise resistance to the infection by some means, and are sometimes a factor in preventing mastoiditis.

In conclusion, may I state that an adequate comprehension of the basic principles of anatomy, physiology and pathology, after all, is the deciding factor in the sensible management of otitis media.

923 Security Building.

DISCUSSION

ROBERT C. MARTIN, M. D. (384 Post Street, San Francisco).—Doctor Harner has covered a wide field in this paper and done it so thoroughly it is difficult to generalize about cases of otitis media, as each case is a law unto itself. Fortunately he has laid down broad, general plans of treatment.

The treatment by irrigation is the only practicable one for the average case since the mother or nurse is not trained to properly place and remove gauze wicks which must be done several times daily if it is to act as a drain and not a blocking foreign body.

The use of phenol and glycerin except for the control of pain is greatly overdone. It produces a soggy epithelial débris which offers a rich field for secondary infection. For this reason it should be used for only a brief period.

We have not found oily nose drops detrimental clinically, and do not believe a sufficient quantity is used to cause lung difficulties through aspiration. Our objection is based on their lack of efficiency since they fail to open a nose already clogged by secretion. Aqueous solutions of weak adrenalin or ephedrin have seemed to us more suitable.

Paracentesis should be done early and constitute an incision, not a mere puncture of the drum. For this reason we prefer a light general anesthesia whenever possible. Repeated paracentesis, after a thoroughly done initial one, seem to us usually to indicate an overlooked mastoid. There are, of course, exceptions to this generalization.

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ROBERT STEELE IRVINE, M. D. (490 Post Street, San Francisco).—There is one feature which I have observed frequently in the middle-ear infections which Doctor Harner has not stressed. This is the simultaneous occurrence of nasal sinusitis of the same side, particularly demonstrable in the maxillary. This applies both to children and adults, and I dare say that if the doctor had performed his paracentesis under general anesthesia and had aspirated the maxillary sinus at that time, he would have been amazed to note the frequency of the presence of pus or mucopus. Under those circumstances the period of the disease may be considerably shortened by making a small window under the inferior turbinate and following up with shrinking medication. Many cases of chronic middle-ear disease which resist treatment have been materially benefited by this treatment.

In the case of adults the problem is more simple, and it is my routine in every case of nontraumatic middle-ear abscess to investigate and enter the nasal sinuses, particularly the maxillaries.

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ORRIE E. GHRIST, M. D. (143 North Brand Boulevard, Glendale).—In small children, after paracentesis has been done and the ear syringed for the first twenty-four hours, I have at times noted the child swallowing during irrigation. This, of course, indicates a patency of the eustachian tube and the ear needs, therefore, no further irrigation.

I also wish to emphasize Doctor Harner's statement that "oils containing menthol and camphor should not be used in the nose and pharynx." Many patients in good health with a normal mucous membrane find camphor and menthol will sometimes irritate the nose. We should, therefore, not use them on the delicate inflamed membrane of a child with an acute otitis media.

DOCTOR HARNER (Closing).—I am gratified to learn that others have discarded the indiscriminate use of phenolized glycerin in acute otitis media where there is profuse purulent discharge. Before the drum membrane has ruptured or has been opened, this is good therapy, but most certainly defeats the purposes of drainage in the presence of excessive discharge. A wide, free incision is essential, as Doctor Martin has stated.

Making a puncture into the maxillary sinuses of children, I am very reluctant to do. In my experience, treatment of the nose by use of a shrinking solution and mild suction is much the better treatment. I have found that these sinus infections are also materially improved by removing the tonsils and adenoids, especially the adenoids. Only occasionally is it necessary to interfere surgically in infections of the sinuses of children.

THE OBSTRUCTING PROSTATE—ITS SURGICAL TREATMENT*

By NATHAN G. HALE, M. D.
Sacramento

DISCUSSION *by Wilbur B. Parker, M. D., Los Angeles; Thomas E. Gibson, M. D., San Francisco; Frank S. Dillingham, M. D., Los Angeles.*

IN reviewing the literature relating to the major operative procedures for removal of prostatic hypertrophy, with particular study of the two broad groups—suprapubic and perineal prostatectomy, one becomes interested in segregating the facts relating to the efficacy of the two types of operation, and surprised at the marked difference in mortality following prostatectomy in different institutions and in the hands of different surgeons.

It is worthy of some comment that as a rule operative procedures, either suprapubic or perineal, performed in county hospitals and like institutions have a much higher mortality and many more complications than the same operative procedures performed in a teaching institution, surrounded by all technical and educational facilities for having any operative procedure advantageously performed with the lowest possible mortality. However, there is no doubt some truth in the statement that the majority of operations on the prostate are not performed in either of the above-mentioned institutions, charitable or teaching, and for that reason it would seem worth while to investigate the statistics of operative procedures in privately owned hospitals, where no particular attention is paid to specialties but particular attention to maintaining a satisfactory workshop.

REVIEW OF SERIES OF SEVENTY-ONE PROSTATECTOMIES

I therefore wish to review a series of perineal and suprapubic prostatectomies performed at the Sutter Hospital in Sacramento, covering a period of six years and based on a study of seventy-one prostatectomies performed on patients ranging in age from fifty to ninety-five and averaging sixty-one years, forty having had suprapubic and twenty-eight perineal prostatectomies. The remaining three not listed were patients admitted

* Read before the Urology Section of the California Medical Association at the fifty-ninth annual session at Del Monte, April 28 to May 1, 1930.

for possible prostatectomy but who expired before operation could be performed. For fairness, from a statistical standpoint, the three patients mentioned have been included. The mortality rate for the seventy-one patients was eight per cent.

I feel that this résumé is perhaps of more general benefit and will give a better idea of the work done in such a hospital because the series of prostatectomies include different types of procedure. Before investigating this series I was quite certain that most of my work had been perineal and was surprised to find that the larger percentage was of the suprapubic type. Several reasons influenced the choice of the suprapubic prostatectomy. First, it is more popular with the general practitioner who refers the patient. There were a few of these patients whom the attending physician had advised to undergo only the suprapubic operation. In this series of suprapubic procedures there were two patients who, before being referred, had had a suprapubic drainage. If the ischial arches were narrowed, making it difficult to use the perineal retractors, or if the perineum had previously been operated upon for any cause, the perineal procedure was not advised. On the contrary, if the patient had a large hernia, was very obese or was considered a poor surgical risk, perineal prostatectomy was given preference.

Of the forty suprapubic prostatectomies seven were performed in two stages—preliminary drainage, followed by blind enucleation. Four of the seven were necessarily operated upon in this way due to failure of the retention catheter properly to drain the bladder, and one because of an epididymitis which was present on admission. The reason I have not customarily advocated a two-stage prostatectomy is that a retention urethral catheter gives the same result, essentially that of an increase in kidney function, thus making the patient a better operative risk. I do not feel satisfied that the two-stage operation does not lose more by attempting to wall off the space of Retzius than it gains, since it thereby converts a visual operation into a blind manipulative separation of tissue. I further base my conclusions, from another angle, on two operations: one performed a number of years ago in which the preliminary drainage procedure was the cause of pubic periostitis; and the other, an operation on a patient in this group in whom the preliminary first-stage procedure resulted in a collection of pus in the prevesical space which dissected the fascia of the abdominal muscles lying next to the peritoneum, the pus remaining undiscovered and never producing a temperature of more than 99.2. The second-stage operation resulted in death on the third postoperative day, though no shock or symptoms were consequent on removal of the prostate. The autopsy findings were those previously mentioned.

PRELIMINARY PREPARATION

The preliminary preparation of patients in the perineal group averaged thirteen days; in the suprapubic group, between twelve and thirteen days. Postoperative time in hospital, which means the time in the hospital after removal of the prostate, averaged between eighteen and nineteen days for the perineal and between twenty-five and twenty-six days for the suprapubic group. I do not think there should be such a marked difference between perineal and suprapubic postoperative time. I feel that if the number of perineal procedures had been the same the average would perhaps have been more nearly the same.

CHOICE OF ANESTHETIC

The anesthetic of choice for the suprapubic group was nitrous oxid and oxygen. This was particularly true of the early cases, those operated upon in 1924 and 1925. Practically 90 per cent of the suprapubic operations were performed upon under general anesthesia and 10 per cent under spinal or local infiltration. I wish here to state that as an anesthetic of choice for suprapubic prostatectomy, spinal anesthesia is superseding any of the other anesthetics and should have been used more in this series than the records indicate.

In the perineal group the reverse is true of anesthesia. Less than 10 per cent had general anesthesia while 90 per cent had sacral, some being sacral and parasacral. Of this group, sixteen patients were given sacral anesthesia alone, which was effective except in one instance. Thirty-three cubic centimeters of three per cent solution of novocain was used in normal salt, a preliminary hypodermic injection of ephedrin having been given nine patients. The one instance of improper anesthesia was due to faulty technique. The solution was not placed in the canal and it was necessary to resort to general anesthesia. I see no reason for giving spinal anesthesia in this group when a sacral anesthesia is easily given with few, if any, alarming symptoms. The technique is practically as simple as that in spinal anesthesia and quite as efficacious. One might reason that some of the deaths from suprapubic prostatectomy were due to the type of anesthesia given. I have little doubt that one patient who was given a general anesthesia and who expired a few hours after operation, would have had a better chance had local anesthesia been used.

PRELIMINARY CARE

In the preliminary care of these patients, fluids were forced by mouth, a gallon per twenty-four-hour period being the usual intake. The patient was made comfortable. If he was accustomed to wearing heavy underwear when in bed, the same type of underwear was given him. In other words, the habits of the patient of sixty years of age or more were not disturbed or interfered with, either in his style of clothing or the amount or variety of food except in instances where change seemed necessary. The patient was semi-ambulatory. Retention catheters, changed frequently, were always used; and the bladder was irrigated at intervals. Preliminary cardiac medication was used in ten patients, postoperative cardiac medication being used in sixteen. The phthalein test

was the principal one used for kidney function, blood urea nitrogen being used for patients with phthalein below 20 per cent after two hours and ten minutes. If the phthalein and blood urea were low but constant and the general condition of the patient satisfactory in the judgment of the surgeon, operation was performed. In the few cases where this was necessary there were no unsatisfactory postoperative results. For all patients who entered the hospital seriously ill from uremic symptoms or from infections of the urinary tract an internist was called in consultation. His assistance proved to be a valuable adjunct.

CONCURRENT COMPLICATIONS

The idea is prevalent that patients who go to public institutions for this type of work are in much worse physical condition than those brought to private institutions. The consensus of opinion is that the mortality rate would therefore naturally be higher. However, it is interesting to compare the patients of this series treated at a private hospital. Two came in practically in uremic coma, two with auricular fibrillation, two with recent attacks of jaundice and chronic gall-bladder symptoms, one a dement, one with a large ureteral calculus and another with a fair-sized kidney calculus. Two were tuberculous.

Of the group which received operation a preliminary diagnosis of the benign enlargement of the prostate was made in sixty-six, and a diagnosis of malignant growth in five, the postoperative laboratory microscopical findings proving twelve to be malignant and fifty-nine benign.

Accordingly, from this rather small series one may form the opinion that patients of this age, regardless of social status, have the same number of complications and serious diseases associated with their prostatic hypertrophy.

POSTOPERATIVE COURSE

The postoperative course of both groups was far from uneventful. Two patients with perineal prostatectomies had secondary hemorrhages. One hemorrhage was caused by the use of a recently advocated bag method of control which, in my hands, was not satisfactory. I have since returned to the procedure of carefully tying all bleeding arteries and veins. The other secondary hemorrhage occurred eight days after operation in a tuberculous patient. Six patients developed epididymitis following operation; four following perineal and two following suprapubic prostatectomy. One developed abscess of the thigh near the site where normal salt had been given and another developed a large carbuncle in the gluteal region. The last-mentioned complication occurred in the patient who had the secondary hemorrhage due to improper use of a perineal hemostatic bag. One suprapubic operation was followed by a thrombosis of the left leg. One pneumonia followed general anesthesia, and one followed local. Jaundice occurred in two patients following a suprapubic operation, both patients, however, having a previous history of jaundice and gall-bladder attacks. In neither instance were stones found by x-ray. In two patients of the suprapubic series there was an auricular fibrillation, present before, and demonstrated after operation. The patients with auricular fibrillation were anesthetized, one under local infiltration and sacral anesthesia, and one under spinal anesthesia.

Out of this group, three deaths followed suprapubic prostatectomy and no deaths followed perineal procedure. Three expired before any operative procedure could be performed, but were potential prostatectomies. The causes of death in the suprapubic group are given to show that the type of operation had nothing to do with the death, with one exception. That patient, eighty-nine years of age, had a two-stage prostatectomy and at the time of the second stage—while reaching for a glass of water on the second postoperative day—fell from his bed to the floor, with the drainage apparatus sutured to the abdominal wall and fastened securely to the bed. This trauma and the manipulation of returning the patient to bed, with the already general serious physical handicaps, resulted in his death.

The second death was caused by an undiagnosed abscess between the abdominal muscles and peritoneum which had collected in that region following the first stage. The trauma resultant at the time of the second stage was not sufficient to cause the abscess to drain in the suprapubic region, but was sufficient to cause an extension of this infected material.

The third death was caused by a cardiac embolus. A general anesthesia had been given.

SELECTION OF OPERATIVE PROCEDURE

The type of operative procedure should be mentioned in order to differentiate the perineal as sometimes advocated from the perineal type of operation that should be done. The blind perineal enucleation of the prostate, in my mind, is more dangerous than any other prostatic operative procedure because not only is the procedure itself difficult to perform, but the end result is necessarily more complicated, due to the proximity of the muscles of urinary control and the rectum.

The usual classical operation of Young, with lateral incisions in either side of the midline in the prostatic capsule posteriorly and enucleation of the adenoma, was performed in fourteen perineal prostatectomies. In the other fourteen the type of incision of the capsule advocated by Hinman was used. Of the two procedures, for a view of the operative field after the prostate has been enucleated, I feel that Hinman's is the better. The probability in the usual Young procedure of leaving a small adenoma, which may later grow and obstruct, is eliminated by this procedure; and if it were possible in all cases to go posteriorly as far as Doctor Hinman advocates, leaving the so-called sphincter region unmolested, I feel that the procedure would be better in every respect. In a few patients, however, due to lack of experience, it has been my misfortune to have had a delayed urinary control result. There is no doubt

that Hinman's is a cleaner enucleation and when properly performed the patient has been able to void all the urine normally as early as the seventh or eighth day. This ability I have been unable to find in any of my previous records of prostatectomies, a series of one hundred, performed several years ago.

In the suprapubic procedure the transverse incision advocated by MacGowan was used but once. The usual midline incision has been made, great care being taken to expose the bladder at its highest point near the junction of the urachus before incising, the prostate being enucleated under vision and in most instances the orifice being sutured. In each instance a Pilcher bag had been used with traction and air, prevesical drains, and a large suprapubic tube.

In no case has there been the three-stage operative procedure as recently advocated by Keyes, and in no instance has there been a preliminary vasectomy.

POSTOPERATIVE CARE

As a rule most of the patients had special nursing for two days and nights. The postoperative routine of fluids by hypodermoclysis was always prescribed, at least 1500 cubic centimeters being given. The patient was kept comfortable and the necessary therapeutic measures administered. Very few medicines given by mouth seemed to influence the course of the convalescence. Digitalis, morphin, normal salt, glucose solution intravenously and blood transfusions were of dependable therapeutic value. Irrigation of the tubes and drains was only for removal of clots or obstructions and not for their antiseptic value.

The drainage apparatus in suprapubic prostatectomy has been varied and complicated. Simple drainage methods apparently were the best in my hands. I find that the Connell bottle and the suction apparatus advocated by Barringer are good. The tubes and drains are removed as early as possible postoperatively and urethral catheters inserted early for drainage purposes. These urethral catheters are of doubtful value except as an aid in keeping the patient dry. I feel that their use is one of the causes of the rather high percentage of epididymitis.

UNTOWARD RESULTS

Various untoward results have been observed. A persistent partial incontinence followed a suprapubic prostatectomy of a small fibrous prostate, the patient having multiple strictures of the urethra. The cause of the incontinence may be attributed to the fact that the Pilcher bag was kept distended, creating pressure against the prostatic bed for thirty-six hours. As a rule the Pilcher bag is relieved of pressure and distention within a few hours, and when necessary, pressure is reapplied.

One patient from whom a very large prostate was removed reports that the suprapubic incision has broken down once since leaving the hospital but has healed again. He voids a stream of only fair size and force, which indicates that there is a possible obstruction, either due to a prostatic adenoma not removed or to fibrous bands formed in the region of enucleation. Neither supposition has been verified.

One patient, eighty-two years of age, weighing ninety pounds and having a microscopic diagnosis of carcinoma of the prostate, developed urethrorectal fistula eight days after a perineal operation. This fistulous tract healed without interference at the end of twelve weeks.

Control of urination was delayed by the use of the apparatus for control of hemorrhage, already mentioned, with which I was not familiar. The type of operation in this case was complete enucleation of the prostate as advocated by Hinman.

QUESTIONNAIRES

Sixty-five questionnaires were sent to patients in this series, to twenty-one of which there were no replies; twenty-two had died, seven of carcinoma. In two of these seven, however, the carcinoma was not of the prostate, one being of the rectum and one of the stomach.

Twenty-two replies were had from patients who were living and well, and who had no urinary disturbance; eight stated that they had frequency, which averaged six times per day. Fourteen stated "no frequency." Thirteen get up to void at night, an average of two times, and nine do not void at night. The approximate times when these voidings occur is between 3 and 6 a. m. The size and force of the stream is good in sixteen, medium in four, and fair in two. No burning on urination is reported. There are three with urgency, none with difficulty of urination, and one with occasional dribbling of urine. Nineteen reported the urine as clear, and three as cloudy. Four patients reported they have had epididymitis since leaving the hospital. One of these was a mistaken diagnosis, the so-called epididymitis or swelling of the testicle being a hydrocele. The control of urine was good in nineteen and fair in three. All of the twenty-two report a gain in weight following operation; twenty-one report their general health improved; one reports general health remains the same. Twenty-one report themselves "cured" of prostatic trouble and the one not answered is the case where there has been suprapubic drainage since leaving the hospital, which later closed. All of the twenty-two have been free of serious illness since operation. One reports a small hernia at the site of the suprapubic incision.

CONCLUSIONS

Certain conclusions may be drawn from this study:

Patients of this age, regardless of social status, have the same number of complications and serious diseases associated with prostatic hypertrophy.

The care which the patient receives before operation is very important and cannot be overstressed, but only a few therapeutic aides, properly given, are required.

Epididymitis is a too common complication in this series and could no doubt have been decreased

considerably had vasectomy been performed preliminary to prostatectomy, especially since the writer resorted to the early use of indwelling catheters.

The suprapubic prostatectomy is a recognized procedure of merit, but from the nature of the method of drainage the mortality must necessarily be slightly higher. However, the mortality from preliminary treatment or complications of other organs cannot vary a great deal from that of the perineal.

The type of operative procedure performed on the properly prepared patient will have the same end result, but the logical operative procedure should be the perineal, especially when a method has been satisfactorily perfected for the complete enucleation of the prostate and for obviation to a greater degree of the danger of destruction of the transversus perinei.

Medico-Dental Building.

DISCUSSION

WILBUR B. PARKER, M. D. (527 West Seventh Street, Los Angeles).—Doctor Hale's review is refreshing in its sincerity and is to be commended for its statistical perfection. I believe it is well that surveys such as this be made in all hospitals, and no doubt if this were done we would be bewildered by the conflict of opinions which would result.

With reference to this series and particular reference to numerous other recent reviews and presentations of so-called one hundred consecutive cases, I wish to call to your attention one significant observation. This constitutes an omission on the part of contributors to call to your attention several of the most common complications of an obstruction to the urinary outflow, namely, the posterior median bar formation and generalized contracture of the vesical neck. They are consistently found in all types of obstructions and are more common in the fibrous or prostatic atrophy type and must be relieved by special methods, whether approached by either perineal or suprapubic routes. Therefore, it is inconceivable that any individual could select a series of one hundred consecutive cases of obstructing prostates and relieve them by their reported method without some attention to the often involved bladder neck.

Further, none of the great clinics in this country have been able to present a review of this character nor have they advocated that the relief of an obstructing prostate be entirely confined to one method of approach. There is no doubt that there are types of obstructing prostates which occur in which the proper procedure is better performed by the perineal route than the suprapubic route, and it is equally true that the suprapubic route is at times superior to the perineal route. I personally do not believe that the mortality rate is increased by either method, granting that the operator is properly trained in his work.

I believe there is no necessity for any of the methods to be characterized as "blind operations," and I have yet to experience a second-stage procedure that could not be made a visual operation and with greater ease in those cases in which the space of Retzius had been properly cared for in the initial cystotomy.

I wish to commend Doctor Hale upon bringing to your attention the matter of vasectomy for the prevention of epididymitis. By this simple procedure the patient as well as the surgeon can be saved a vast amount of pain and anxiety.

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THOMAS E. GIBSON, M. D. (450 Sutter Street, San Francisco).—In the discussion of his results with the two operations of suprapubic and perineal prostatectomy, Doctor Hale exhibits a palpable frankness and absence of bias which deserves commendation. Unfortunately, it is seldom that one finds a urologist who is expert in both types of operation. Although the type of operation is usually of little importance, there are a few conditions where there are very definite indications for either the perineal or the suprapubic approach. Doctor Hale has mentioned some of these indications. The perineal approach is the only logical one for the radical removal of prostatic malignancy, and in certain cases of hypertrophy associated with infection a seminal vesiculectomy as well as a prostatectomy can be advantageously performed. The preliminary preparation in Doctor Hale's series averaged about thirteen days, showing that he is alive to the importance of thorough preparation. This is the greatest single factor in the successful treatment of prostatic hypertrophy. The operation is but an incident in the course of treatment. Liaison with an internist is almost indispensable in these cases. Spinal anesthesia has come into personal favor almost to the exclusion of other forms of anesthesia. With the preliminary use of ephedrin I believe it to be as safe as sacral and parasacral anesthesia, easier to give and more certain in its action. Approximately 17 per cent of Doctor Hale's cases proved to be malignant. This coincides with statistics from other sources. One of the most annoying postoperative complications of prostatectomy is epididymitis. Statistics show an incidence varying from 25 to 50 per cent, so that vas ligation or resection before or at the time of operation is a good prophylactic measure. The most serious immediate complication of prostatectomy is hemorrhage. Of the many procedures advocated for its control the one which deserves most attention is adequate exposure of the field and control of bleeding by ligature or suture. The use of packs or rubber bags should be avoided except as a last resort because of the discomfort they cause, and because they delay wound healing. For the last few years I have been applying this principle to perineal prostatectomy and performing a complete plastic closure of the wound, with the result that primary union without drainage through the wound occurs in the majority of cases with distinct shortening of convalescence.

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FRANK S. DILLINGHAM, M. D. (548 South Spring Street, Los Angeles).—As Doctor Gibson has said, "Operation is but an incident in the course of treatment." Each patient must be carefully studied to determine how long preoperative treatment must be continued to insure maximal clinical improvement as shown by blood chemistry, urine, heart, lungs, and kidneys. In the suprapubic operation it is important not to be rough, to protect the space of Retzius and the perivesicle tissues by sutures as suggested by Doctor MacGowan, or such care in handling as not to traumatize and infect these parts. Doctor Peterkin's suggestion for draping the patient is very useful, as the surgeon can rapidly insert one or more fingers of his left hand in the patient's rectum to steady or lift the prostate gland. If the proper line of cleavage is followed, the tumor may usually be gently enucleated in one piece with the least amount of damage to the bladder neck and urethra and with only a moderate amount of bleeding. If there should be severe hemorrhage, prompt ligature of the bleeding vessels, which are found usually at "4 and 8 o'clock," is better than the use of bags or packing. I close the bladder with a double row of chromic sutures around a No. 30 F. rectal tube with eyes at end and sides, and a No. 8 F. catheter attached to the side. The muscles, fascia, and skin are approximated, but the sutures are not tied too tightly, as there always is some increased tension for the first two or three days. A Penrose rubber drain, without gauze, rolled not larger than a cigarette, is placed at the upper and lower angle, but not forced into the space of Retzius. A continuous drip of normal salt or Thiersch solution is started in the No. 8 F. catheter and out by the larger tube, which prevents clots and tenesmus. The oozing is usually stopped in six to twelve hours, the patient being dry and comfortable all the time.

Later, if the urethral catheter does not enter the bladder at the first try there is less danger of causing an epididymitis if a wire stylet or catheter guide is used to lift the end of the catheter out of the prostatic bed into the cavity of the bladder.

In the last few years the perineal operation has been improved, the gland removed usually in one piece, and in selected cases the capsule, muscle and fascia closed, saving the patient several weeks of convalescence. The perineal route is the only logical approach when early malignancy or tuberculous infections exist or where seminal vesiculectomy should be performed at the same time. I have used spinal anesthesia in all prostatic and bladder surgery since 1903, and am glad to see the pendulum swinging back to its more popular use.

CARE OF CALIFORNIA'S MENTALLY SICK*

SOME PROPOSED CHANGES IN THE LUNACY LAWS

By GEORGE G. HUNTER, M. D.
Los Angeles

AT a meeting of the state council of the California Medical Association in San Francisco on January 31, the writer presented certain amendments to the California lunacy laws. These proposed amendments were recently sponsored by the Southern California Psychopathic Association and by many of the Los Angeles physicians interested in the matter. The Council very generously approved the amendments and instructed the California Medical Association Committee on Public Policy and Legislation to aid in their passage.

NEED OF BETTER LUNACY LAWS

For a number of years medical men in Southern California whose work has familiarized them with the conditions under discussion, as they obtain at the present time, have felt the need of a general revision of the California lunacy laws not only to better coördinate and simplify and to remove unnecessary legal and administrative delay, but to clarify and emphasize the fact that insanity and mental sickness is after all a problem in the domain of medical science and ought to have no more to do with legal machinery than is absolutely necessary to safeguard the constitutional rights of the individual. The increasing number of the mentally sick gives a special significance to this problem.†

PROGRESS SLOW BUT STEADY

Fortunately there is being built up all over the country by a slow, educative process a considerable group of intelligent, influential citizens who are in sympathy with this concept. However, the legal machinery and the attitude of the average uninformed man still leaves much to be desired. One needs but little observation of the daily grind of many of our lunacy courts and the jury hearings in lunacy trials to realize the vast amount of suspicion and distrust still held toward the physician, and the profound ignorance in the minds of many lay people regarding the whole matter. That the determination of sanity, the disposition of the insane, their treatment and management should be submitted to final decisions of lay persons in the form of our usual juries must seem to scientific medical men or intelligent lay thinkers not only an absurdity but a travesty upon justice. Some attempt has been made to change the practice of jury hearings in lunacy matters, but the fear on the part of certain groups in society that it would be an opening wedge against the jury system as a whole has so far thwarted reform in this direction.

LUNACY LAWS NEED REWRITING

The problem of entirely rewriting our lunacy laws to bring them into harmony with the intelligent public trend toward mental hygiene and the scientific, humane handling of the mentally sick is a task of considerable scope and will require careful study by some authoritative body or groups thoroughly familiar with all phases of the work. In California the most intelligent approach to such a study was made last year by the committee conducting the state mental hygiene survey, and it is to be hoped that as a result of this study some constructive, well thought out, coördinated system may be inaugurated.

In the meantime some amendments to make the present laws a little more flexible, a little more humane and a little more in harmony with the ideas expressed above seem very desirable to many of the medical men who are obliged to meet their daily problems under the present law.

AMENDMENTS NOW SUBMITTED

Our southern California group of citizens who are interested in this work have five or six measures which it is hoped will be favorably acted upon by the legislature, which is now in session, and it is to these amendments that the Council of the California Medical Association gave its approval.

STIGMA OF IMMEDIATE ARREST—WHY THIS HUMILIATION?

Section 2168 at present provides arbitrarily that upon issuance of a warrant by a judge the patient shall be arrested and taken before a judge of the Superior Court of the county for a hearing and examination on such charge, and that upon arrest the arresting officer shall detain such person until an examination and hearing can be had.

We wish to amend this section by insertion of the clause that "pending examination and hearing such order may be made relative to the care,

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* This is a discussion of a report on this matter by a committee, with headquarters in Los Angeles.

† Editor's Note.—The "World Almanac," edition of 1931, page 451, gives the total number of patients in state hospitals for mental diseases. The totals for the United States by different census decades are: Year 1880 was 31,973 inmates; year 1890 was 67,754; year 1910 was 159,096; year 1922 was 222,406; year 1928 was 264,226 inmates.

For California the totals are: Year 1880 was 1851 inmates; year 1890 was 3410; year 1910 was 6560; year 1922 was 11,055; year 1928 was 13,318 inmates.

These figures are indicative of the magnitude of this important problem. See, also, special article on "California State Mental Hygiene Survey" in California and Western Medicine, December 1930, page 872.